DOCUMENT RESUME

ED 444 073 CG 030 172

AUTHOR Hopper, Melissa T.
TITLE The Relationship between Attachment Status and Personality Disorders.
PUB DATE 2000-05-00
NOTE 62p.; Doctoral Research Paper, Biola University.
PUB TYPE Dissertations/Theses - Doctoral Dissertations (041)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Attachment Behavior; Counseling; *Counselor Training; Literature Reviews; Mental Disorders; *Parent Child Relationship; *Personality Problems

ABSTRACT

This research paper provides information that would be useful to practicing counselors and counselors in training. It reviews the relevant research pertaining to the relationship between attachment status and personality disorders. It also critiques methodological issues, including major assessment instruments and frequently used research designs. Discussion begins with an overview of the relationship between attachment status and general psychopathology and progresses to personality disorders. Several specific disorders and their correlations to specific attachment disorders are discussed, including Borderline, Schizoid, Avoidant, and Dependent Personality Disorders. Implications for further research and treatment are discussed. Of particular interest is a 1988 study that found that attachment status not only affects the individuals themselves, but also those in relationships with them. Parents who were described as having avoidant attachment tended to be the parents of insecure-avoidant children. Likewise, parents described as having a preoccupied attachment and who had often idealized their relationships with their own parents frequently had children categorized as insecure-ambivalent. A final group of parents who had experienced the death of an attachment figure in childhood and had not successfully resolved that loss had infants described as insecure-disorganized/disoriented. (Contains 36 references.) (MKA)

THE RELATIONSHIP BETWEEN ATTACHMENT STATUS AND PERSONALITY DISORDERS

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

---

by

Melissa T. Hopper

May, 2000

THE RELATIONSHIP BETWEEN ATTACHMENT

STATUS AND PERSONALITY

DISORDERS

by

Melissa T. Hopper

APPROVED:

Cherry Steinmeier, PsyD Date 5/4/00

Joan W. Jones, PsyD Date 5-4-00

APPROVED:

Patricia L. Pike, PhD, Dean

5/4/00
Date

ABSTRACT

THE RELATIONSHIP BETWEEN ATTACHMENT STATUS AND PERSONALITY DISORDERS

by

Melissa T. Hopper

Relevant research pertaining to the relationship between attachment status and personality disorders is reviewed. Methodological issues are critiqued, including major assessment instruments and frequently used research designs. Discussion begins with an overview of the relationship between attachment status and general psychopathology and progresses to an examination of the relationship of disorders of attachment to personality disorders. Several specific disorders and their correlations to specific attachment disorders are discussed, including Borderline, Schizoid, Avoidant, and Dependent Personality Disorders. Implications for further research and treatment are also discussed.

TABLE OF CONTENTS

PAGE

THE RELATIONSHIP BETWEEN ATTACHMENT STATUS AND PERSONALITY DISORDERS

Introduction

Healthy development depends upon healthy attachment. According to Bowlby (1977), attachment is necessary for one to experience strong relationships with himself and others. He further stated that attachment behavior continues to characterize human beings throughout life (Kestenbaum, 1984). Beginning with Bowlby's writings on the topic, attachment has been investigated with increasing thoroughness in the past 30 years. As this study and research have increased, more has been learned about attachment's importance in human development. Yet, what occurs when one fails to attach to a primary caregiver or other? This paper will address the relationship between attachment status and the development of psychopathology, particularly personality disorders.

This paper overviews the literature pertaining to attachment and personality disorders. It will begin by briefly surveying the major assessment instruments utilized to obtain data and by defining the commonly used terms. Special attention will be given to investigating the samples used in

the research and implications for their results. This overview will continue by discussing attachment and pathology in general, and personality disorders in particular. Specifically, Borderline, Schizoid, Avoidant, Antisocial, Dependent, and Self-Defeating Personality Disorders will be discussed. Implications for treatment and further research will conclude the paper.

Methodological Considerations

Though the studies examined in this literature review do appear to link attachment status with the presence or absence of personality disorders, there are a number of methodological considerations that should be noted. Within this particular field of study, many of these considerations are pragmatic, yet they nonetheless affect the generalizability of the results and should be considered before any broad conclusions are offered. For the purposes of organization, these methodological problems will be divided into three basic categories: definitions, instrumentation, and sampling.

Definitions

One important consideration in reviewing this body of literature is the definition of commonly used terms. Although both attachment and personality disorders are similarly defined across the literature, there is some variability.

Attachment. The origins of attachment theory can be traced to John Bowlby. He defined attachment as a bond developed with "some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser" (Bowlby, 1977, p. 203). He listed the following defining features of attachment and attachment behavior: attachments are directed toward specific individuals, are characterized by their long duration, and serve the biological function of survival. Attachment has a strong positive emotional component while being formed, maintained, or renewed. It also has a strong negative component when it is threatened or lost. Bowlby's definition and characterization of attachment are widely used across the literature with little exception (Dozier, Stevenson, Lee, & Velligan, 1992; Allen, Hauser, Borman-Spurell, 1996; Sheldon & West, 1990; etc.).

Disorders of attachment. The loss of an attachment figure or the emotional unavailability of an attachment figure may result in an attachment disorder (AD). The research in this area generally classifies attachment into three main categories: secure attachment, dismissing of attachment and preoccupation with attachment (Pianta, Egeland, & Adam, 1996, Paterson & Moran, 1988, Dozier et al., 1991). This classification is based on the Ainsworth's Strange Situation which observed a child's strategy for maintaining access to attachment figures when in a distressing situation (Ainsworth, Blehar, Waters, & Wall, 1978). A secure attachment strategy

allows the individual fully to attend to and integrate information about the attachment figure. This strategy is guided by the assumption that the caregiver will be available and responsive. Securely attached individuals are considered the healthiest. Those individuals with a dismissing strategy, also called deactivating, seem not to notice their caregiver's absence and often fail to seek out contact upon reunion. They may fail to attend to information that is relevant to maintaining access to an attachment figure. Finally, individuals with a preoccupation with attachment, also called hyperactivating strategy, are caught up, or enmeshed, in the negative effects of attachment experiences. These attachment strategies have implications for interpersonal behavior (Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target, & Gerber, 1996), and it is presumed that the same processes that regulate childhood attachment systems will continue to operate in adulthood (Dozier et al., 1991). Individuals with a secure strategy assume that their interpersonal needs will be met and therefore act accordingly. Individuals with a dismissive strategy may present themselves as not needing others (Dozier et al., 1991), and may have developed strategies for minimizing distress (Dozier & Lee, 1995). Finally those relying on preoccupied strategies may present themselves as needy, but may anticipate that their needs will not be met (Dozier et al., 1991). Unlike those with dismissing strategies,

those with a preoccupation for attachment do not minimize distress, rather they may even exaggerate or maximize distress (Dozier & Lee, 1995).

The above classification of attachment and disorders of attachment is generally used across the literature. However, one study added the category of fearful attachment which is associated with social inhibition, a lack of assertiveness, and a combination of avoidant and preoccupied traits (Alexander, 1993).

Personality disorders. The definition of personality disorders (PD) is also somewhat problematic, not necessarily due to inconsistency on the part of the authors, but due to continual modifications in the diagnostic criteria for the disorders. All of the studies encompassed in this review define PD based on the criteria provided by the Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R; American Psychiatric Association [APA], 1987). The use of this manual unfortunate because the current DSM-IV (APA, 1994) is now considered the standard for diagnosis. Although both editions define PDs similarly, any differences between the two will be noted in this review.

Instrumentation

The second methodological consideration is that of the instrumentation utilized in these studies. Typically, researchers relied on interview data and self-report instruments for all levels of assessment.

Attachment status. In assessing attachment status the generally used measure was the Adult Attachment Interview (AAI). Main and Goldwyn (1991) developed the AAI to provide a context for assessing an adult's ability to process and integrate attachment-related thoughts, feelings, and memories. The AAI is a structured interview that probes individuals' descriptions of their childhood relationships with parents described in abstract terms, as well as with requests for specific and concrete supporting memories. The developers posit that, although attachment status may be measured behaviorally in childhood, it is more difficult to do so in adults. Therefore, attachment status must be measured at the representational level by examining how attachment-related information is processed. The AAI meets stringent psychometric criteria, not only in terms of reliability but also in discriminate and predictive validity. Further, in cross-cultural studies, the AAI was found to be stable over time; independent of interviewer effects or response bias; and unrelated to IQ, and general discourse style (IJzendoorn, Feldbrugge, Derks, de Ruiter, Verhagen, Philipse, van der Staak, Riksen-Walraven, 1997).

The AAI is typically scored either by the Main and Goldwyn (1991) classification system or by the Kobak Q-set (Kobak, 1989). The interview is intended to elicit adults' memories concerning attachment-related experiences and is not intended to be a veridical report of childhood. The

individuals' memories of parental-child behavior, as well as their linguistic behaviors during the interviews, are coded from the transcript according to the chosen classification system (Pianta et al., 1996). Main and Goldwyn's classification system focuses on the subjects' coherence and/or violations of coherence during the discussion of attachment. The information gathered is then used to determine the appropriate attachment category: secure-autonomous, insecure-dismissing, insecure-preoccupied, and unresolved with respect to trauma or loss (Main & Goldwyn, 1991). The first three categories mirror the description of attachment disorders given by Bowlby and others (Bowlby, 1977; Ainsworth et al., 1978; etc.). Individuals classified as "unresolved" may also be classified as secure-autonomous, insecure-dismissing, or insecure-preoccupied. However, these persons demonstrated disorientation in speech and/or thought when questioned about traumatic experiences. In research involving those who have lost an attachment figure or those who have been physically or sexually abused, this disorientation is particularly apparent. An unresolved classification signals the existence of a state of disorganization with respect to attachment (Pianta et al., 1996). In some studies the categories were "forced"; that is, those individuals with an unresolved attachment status were reassigned to the most appropriate other category. Forcing the categories allowed more direct comparison and manipulation; however, forcing the classification may have resulted in an

inaccurate reflection of the true nature of the attachment. Finally, in rare studies the researchers added a "cannot classify" category when none of the choices seemed appropriate. Nonetheless, many of the studies in this overview used the categories developed by Main and Goldwyn (Pianta et al., 1996; Allen et al., 1996; IJzendoorn et al., 1997). Most often two raters were utilized, and their ratings were compared for reliability.

A second scoring system for the AAI is a Q-set developed by Kobak (1989). The 100 Q-items were derived from descriptions of Main and Goldwyn's classification system (Main & Goldwyn, 1991). Similar to Main and Goldwyn's system, raters make attachment classifications and rate subjects on a variety of subscales. Raters use 100 items from the Q-set to describe each subject, placing items in one of nine categories ranging from most to least characteristic of the subject. The two raters' Q-sorts are averaged for each subject, and these averages are correlated with two attachment dimensions (Kobak, 1989). The first dimension differentiates subjects with regard to security/anxiety. High positive correlations would correspond to a secure classification using Main and Goldwyn's systems. The second dimension differentiates subjects with regard to strategies used to reduce distress. High positive correlations are associated with the reliance on avoidant strategies and correspond to a dismissing classification. High negative correlations are associated with the reliance on preoccupied

strategies and correspond to a preoccupied classification (Dozier, 1990). A comparison of the Kobak and Main and Goldwyn systems found that the Q-sort approach was concordant with the Main and Goldwyn classification system for 94% of the subjects originally classified as insecure-dismissing, for 89% originally classified as secure, and for 88% originally classified as insecure-preoccupied (Kobak, Cole, Ferenz-Gillies, & Fleming, 1989).

Although the AAI is helpful, caution should be used. Jones (1996) states that the following is important:

> [one must] guard against the tendency to consider responses to the AAI as representing attachment history. In actuality, the attachment classification system relies on assessing the individual's present state of mind with respect to attachment through language use and can be usefully conceptualized as mental representations of attachments or working models of intimate and important relationships. (p. 6)

In addition to the AAI, several other attachment measures are reported. The Adult Attachment Scale (AAS) (Kooiman & Spinhoven, 1996), the Revised Adult Attachment Scale (RAAS) (Burge, Hammen, Davila, Daley, Paley, Lindberg, Herzberg, & Rudolph, 1997), and the Relationship Questionnaire (RQ) (Alexander, 1993). Further, many researchers developed their own self-report measures related to their studies (Sheldon & West, 1990; West, Rose, & Sheldon-Keller, 1994; West, Rose, & Sheldon-Keller, 1995). These measures will be discussed as they relate to the individual study.

Personality disorders. Generally, researchers used one or more of three methods for assessing a personality disorder. The first included objective measures such as the Minnesota Multiphasic Personality Inventory – 2 (MMPI-2), the Millon Clinical Multiaxial Inventory (MCMI), the Personality Disorder Questionnaire - Revised (PDQ-R), the Rorschach, and clinician ratings (Pianta et al., 1996; West, Rose, & Sheldon, 1993; West, Keller, Links, & Patrick, 1993). The second method involved interview data such as the Structured Clinical Interview for the DSM (SCID), or the Structured Interview for Disorders of Personality - Revised (SID-R) (IJzendoorn et al., 1997; Stalker & Davies, 1995). The third method was the use of self-report measures that were developed by the researchers for their study (Fonagy et al., 1996; Livesley, Schroeder, & Jackson, 1990).

Apart from the problems introduced with the use of author-developed instruments (i.e., researcher subjectivity), it is also clear that even the use of well-standardized, self-report instruments can be problematic and affect the accuracy of the results. Subjects may tend to overreport (trying to please the interviewer) or underreport (perhaps utilizing a defensive coping strategy) without the researcher ever having any indication of such inaccuracies. Thought the self-report nature of some of this body of research is unavoidable, it is nonetheless worthy of consideration when interpreting research results.

Samples

Virtually all of the samples drawn for these studies are non-representative in some respect. However, the most significant issue related to sampling was the predominate use of clinical populations. Further, several articles also used special populations, thereby affecting the generalizability of the results.

Clinical versus general populations. Many, though not all, of the studies utilized non-random clinical samples. Most of the samples were drawn from an outpatient rather than inpatient population; however, it is nonetheless questionable if high rates of ADs and PDs would be found in the general population. It could be hypothesized that those seen in clinical settings, particularly those in inpatient facilities, are likely to be experiencing greater interpersonal difficulties than those not seeking treatment. This hypothesis appears to be confirmed in the research that does compare normal populations with clinical populations (Livesay, Jackson, & Schroeder, 1992; West, Rose et al., 1993; Sack, Sperling, Fagen, & Foelsch, 1996). Such differences between the two populations certainly limit this body of research and therefore, need to be addressed in future study on the topic.

Special populations. The use of special populations was a further sampling issue. Three special populations (child abuse survivors, gay men, and criminals) were found in the literature. The effect these variables may

have had on the results could be dramatic because of extraneous variables. For example, those individuals affected by child abuse, particularly incest, may have a larger amount of attachment difficulty due to the environment in which they were raised. Stalker and Davies (1995) found that sexually abused women were more likely to be classified as unresolved with respect to trauma or loss on the AAI. This larger proportion of unresolved attachment may be directly related to the trauma and loss experienced from the abuse as a child. This same study also found a higher incidence of Borderline PD in sexually abused women. The authors argue that sexually abused women, rather than being characterized as Borderline per se, are struggling more with issues surrounding loss and trauma and are unable psychologically to separate from attachment figures and past experiences (Stalker & Davies, 1995). Further, a similar study by Alexander (1993) found a higher rate of insecure attachment and fearful/disorganized attachment among women who have been sexually abused. It seems that the effects of sexual abuse on men and women may have profound implications for the development of attachment and safety.

The second special population found in the literature is that of HIV positive gay males. In a study by Kooiman and Spinhoven (1996), a higher incidence of personality disorders was found within this group. The authors

attributed this higher rate to high-risk sexual behavior rather than homosexual orientation.

The final special population was in the research conducted on criminal populations. Like the research on sexually abused individuals, research on the criminal population entails a unique history and perspective. It is likely that a higher than normal proportion of PD, particularly Antisocial PD, and AD will be present in this population. In a study by IJendoorn et al. (1997) the researchers compared forensic adults, clinical adults, and non-clinical adults within a low socioeconomic status and found an overrepresentation of unresolved/cannot classify attachment status as measured on the AAI. This study seemed to confirm prior research hypotheses. Further, there was a higher incidence of Antisocial PD within the forensic group. However, it should be noted that when the categories of the AAI were forced, eliminating the unresolved/cannot classify strategy, the distributions found in the criminal population did not differ from the distributions usually found in clinical samples without a criminal background. The authors argued that "insecure attachment may be a general mental health risk factor, rather than a specific determinant of severe criminal behavior" (IJendoorn et al., 1997, p. 456).

Other Procedural Problems

In addition to the methodological considerations described above, other procedural problems, primarily the lack of control groups and the use of retrospective studies, limited this body of literature.

Lack of control groups. One problem with this body of research is the fact that people with ADs may also be subject to numerous other variables that could potentially contribute to the development of a PD. Therefore, it is impossible to infer that attachment disorders cause personality disorders simply on the basis of high correlations.

Nonetheless, the difficulty presented by this issue could have been limited to some degree by the more frequent utilization of a control group, which matched the study group with respect to demographic variables and other types of experiences. Unfortunately, many of the studies reviewed in this paper offer no such controls. Establishing control groups is difficult in any setting; however, the absence of such controls does limit the generalizability of the research results.

Retrospective studies. An additional limitation of this body of literature is that the vast majority of the studies completed to date are retrospective rather than longitudinal. This limitation again raises the question of the accuracy of a subject's self-report via interview. Particularly in studies utilizing the AAI, subjects are asked to recall attachment

experiences and memories. The accuracy of the results depends upon the accuracy of the subject's memory. If a person were to have an existing PD, his or her memory of childhood could be somewhat distorted due to the pathology itself. However, one study reviewed in this paper did use longitudinal data (Allen et al., 1996). These researchers conducted an 11-year follow up on adolescents with severe psychopathology. The results of this study will be discussed in a later section.

Attachment Status and Personality Disorders

For the purposes of this review, it is first necessary to answer the question of whether or not ADs are related to general psychopathology. Theorists have long speculated about the connection (Paterson & Moran, 1988); however, only within recent years has the relationship been empirically researched. After a discussion of this first body of literature, a review of more specific research on attachment status and PDs will follow.

Attachment Status and Psychopathology

As stated earlier, the relationship between attachment and pathology has only recently been researched. Many of the studies focusing on this relationship have utilized adults with severe psychopathology, many of whom have been hospitalized one or more times. Several researchers have investigated the effect attachment strategy has on self-reported measures of

symptomatology, almost to the exclusion of investigating the correlation between attachment and actual pathology, per se (Dozier & Lee, 1995). The impact these studies have on this current review is two-fold. First, it is imperative that one understands how attachment status may affect the results of self-report measures in the following studies. Second, the general relationship between the two variables must be verified to increase the strength of the correlation between ADs and PDs.

In a study by Dozier and Lee (1995), the researchers examined the relationship between a hyperactivating attachment strategy (insecure-preoccupied) and a deactivating attachment strategy (insecure-dismissing) on self-reported symptomatology. They administered the AAI, using the Q-sort method of scoring, the Brief Symptom Inventory which assesses for specific forms of pathology, as well as ratings by both the interviewer and the subject's caseworker. The four scores were compared using an analysis of variance (ANOVA). As expected, the individuals utilizing a hyperactivating attachment style reported generally higher levels of symptoms than the subjects who relied on deactivating strategies (F 1, 74 = 4.86, $p < .05$). The authors proposed that this result was connected to the relating style associated with each strategy. Deactivating or dismissing individuals have developed strategies for minimizing distress, yet clinicians and interviewers rated these subjects as more symptomatic. On the other hand, those persons

with a hyperactivating or preoccupied attachment status do not minimize distress; in fact, they exaggerate it. The contrast may be due to the preoccupied individual's tendency to push away others and reject help from her caseworker. It should be noted that the unresolved classification was not measured in this study, and therefore the categories may have been forced.

A similar study by Dozier (1990) also looked at the impact one's attachment strategy has on treatment. She found that individuals approach treatment in a manner consistent with their attachment strategy. More specifically, those individuals with a hyperactive strategy are typically highly motivated for treatment due to the high levels of distress they report. In contrast, individuals with a dismissing strategy are more likely to refuse or reject help and be less involved in their treatment planning.

Pianta et al. (1996) also found the relationship between attachment strategy and pathology to be strong. In their study of 110 high-risk, pregnant women, they found that those with a hyperactivating strategy reported more symptomatology on the MMPI-2 than those with an autonomous or dismissing strategy. This study is somewhat unique in that the subjects were non-clinical women and that those with an autonomous strategy were included. The results indicate that although those with a hyperactivating strategy had the most MMPI-2 elevations, the subjects with an autonomous strategy had the second highest amount of elevations. The authors

attributed this somewhat unexpected result to the increased honesty and decreased defensiveness in those with healthy attachment. As expected, those with a dismissing style appeared more defensive. This study was conducted on women who had experienced repeated crises, domestic violence, and histories of abuse and neglect in childhood, and the results may not be indicative of the non-clinical population in general. Dozier et al. (1991) also confirmed these results. Their research focused on adults with severe psychopathology and their families. Individuals with a secure attachment had better premorbid functioning than those with either a dismissing or preoccupied style.

Allen et al. (1996) completed the only longitudinal study on attachment and general psychopathology. Their research investigated the effect of severe psychopathology in adolescents on the occurrence of attachment disorders in young-adulthood. They found that the adolescents' hospitalization due to psychopathology was predictive of insecure attachment in young-adulthood. Further they investigated the relationship between criminal behavior and attachment status. More specifically, individuals with a dismissing attachment status and a lack of resolution to trauma were more likely to be involved in criminal behavior in their twenties.

Attachment Status and Personality Disorders

In the previous section, the relationship between attachment status and psychopathology was demonstrated through the literature. Individuals with an AD are more likely to have psychological difficulties. This section will focus on general and specific PDs and their relationship with attachment status.

The majority of the researchers in this area believe that there is a consistent relationship between attachment and PD. Livesay et al. (1992) examined the factorial structure of PDs. Among the factors they believed would influence the development of a PD is attachment status. The study compared individuals with a diagnosis of PD, based on a clinical interview (n = 158), with individuals from the general population, who may or may not have had a PD (n = 274). The individuals were given several self-report measures that used a Likert-type scale to rate behaviors. The researchers controlled for social desirability in the participants by eliminating the items that were strongly correlated with desirability. Coefficient alphas for these scales ranged from .90 to .68. The researchers began by comparing the descriptive properties of 100 scales between their two samples. Several large discrepancies were found. Based on these discrepancies the researchers narrowed factors contributing to PDs to 15 factors. Using a series of t-tests, the two groups were then compared based on the 15 factors. The researchers

were conservative in their calculations, using α of .003 to control for Type I errors. Under this new criterion, 9 of the 15 scales were significant: Generalized Distress, t (430) = 12.58; Affective Reactivity, t (430) = 9.32; Diffidence, t (430) = 8.53; Restricted Expression, t (430) = 7.79; Social Apprehensiveness, t (430) = 7.27; Conduct Problems, t (430) = 6.60; Insecure Attachment, t (430) 6.01; Oppositionality, t (430) 5.39; and Cognitive Dysfunction, t (430) = 4.81. A potential problem with this study is that DSM criteria were not used in the diagnosis of PD. Rather, diagnoses were made on the basis of clinical opinion, which may not have been standardized. The use of clinical opinion allowed PD to be described as clusters rather than as specific PD diagnoses. Both of these issues complicate a direct comparison with similar studies. In general, this study indicates strongly that attachment status is indeed a relevant factor in the development of PD.

In a study of PD and non-clinical gay males, Kooiman and Spinhoven (1996) also sought to investigate the relationship between several factors and PD. Using the Personality Disorder Questionnaire - Revised (PDQ-R) and the Adult Attachment Scale (AAS) the researchers compared the results from the two samples (N = 41). The patients with PD had significantly lower scores for the close, dependent attachment style than did individuals without a PD ($p < .05$). Furthermore, there was a negative and significant correlation between dependent and close attachment and the total score for the PDQ-R,

in particular on the scores for Cluster A (Schizoid, Paranoid, Schizotypal), Cluster C (Avoidant, Dependent, Obsessive-Compulsive, Passive-Aggressive), and Not Otherwise Specified (NOS). After controlling for anxiety and depression, which was measured by the Hospital Anxiety and Depression Scale (HADS), the correlations remained significant between dependent attachment and the total score on the PDQ-R ($r = .52$, $p < .001$), and the scores for Cluster A ($r = -.47$, $p < .01$) and Cluster C ($r = .43$, $p < .01$). There was not a relationship between anxious attachment and the PDQ-R. This lack of correlation contradicts several other studies (West, Keller, et al., 1993; West, Rose, et al., 1993). The researchers also note that the use of the PDQ-R has been known to give rise to many false-positive diagnoses compared to standardized interviews and may have contributed to the larger percentage of individuals in the sample diagnosed with PDs (61%).

Anxious attachment was investigated by West, Rose, et al. (1993). Using self-report measures developed by the researchers, clinical and general populations were compared. The self-report measure demonstrated a satisfactory internal reliability (ranging between .85 to .74). These self-report scales along with the MCMI were administered to respondents of a survey ($n = 136$) and volunteer psychiatric outpatients from a psychotherapy clinic ($n = 110$). Individuals with Schizophrenia or organic mental disorders were excluded. Each psychiatric patient had at least one PD as measured by the

MCMI with Dependent (48%), Avoidant (36%), and Borderline (34%) being the most common. The study used an ANOVA to measure the effects of sex and patient status on three variables: proximity seeking, separation protest, and feared loss. Further, multiple logistic regression was also used to predict patient status based on these variables. There was no evidence of an interaction between sex and patient status in the feared loss scale or in the separation protest scale. However, there was a highly significant main effect of patient status and feared loss (F 1, 239 = 34.35, p = < .001) and separation protest (F 1, 241 = 10.60, p = .001). The logistic regression indicated that feared loss is the most useful scale for differentiating patients from non-patients. The higher the scores on feared loss the more likely an individual is a clinical patient. With the majority of the patients being Dependent PD, Avoidant PD, or Borderline PD, this research seems to confirm the relationship between these disorders and anxious attachment.

In a small study on late adolescent women, Burge et al. (1997) investigated the relationship between attachment cognitions and psychopathology. The sample was drawn from three high schools in the Los Angeles area and included an initial assessment and one-year follow-up. The women were administered the SCID with an interrater reliability of .90 for past symptoms and diagnoses and .89 for current symptoms and diagnoses. The information from the SCID was converted into a 5-point severity scale for

depression, anxiety, substance abuse, and personality disorder. Three of the 143 women met the criteria for a PD and another nine exhibited symptomatology. At the follow-up interview only one woman had a PD diagnosis, and four had symptoms. The women were also administered the Revised Adult Attachment Scale (RAAS) which elicits Likert type responses. The RAAS yields three subscales: Close (extent to which a person feel comfortable with closeness and intimacy), Depend (extent to which person can trust and depend on others), and Anxiety (fear of being abandoned and not loved). The Close and Depend scales of the RAAS were found to be significantly correlated with PD symptomatology at both the initial and follow-up interviews (Close [initial] $\underline{r} = -.17$, $\underline{p} < .05$; Close [follow-up] $\underline{r} = -.21$, $\underline{p} < .01$; Depend [initial] $\underline{r} = -.17$, $\underline{p} < .05$; Depend [follow-up] $\underline{r} = -.23$, $\underline{p} < .01$). This study indicates that those women with poor attachments were more likely to be experiencing PD symptoms. It should be noted that this study was very small with only 12 and 5 women, respectively, with a diagnosis of PD. However, it does demonstrate the need for further research in this area.

Finally, in a study of the long-term effects of sexual abuse, Alexander (1993) examined the relationship between attachment and PD. She stated that sexual abuse may be preceded by insecure attachment and that family dynamics demonstrated in abusive families are consistent with those

observed in families with insecure attachment. Based on this assumption she postulated that measures reflecting basic personality structure would be best predicted by adult attachment in women who were incestuously abused in childhood. She administered 112 women several measures including the Relationship Questionnaire (RQ) and the MCMI. The RQ yields four attachment scales (Secure, Preoccupied, Dismissing, and Fearful). On the MCMI she selected four scales suggestive of basic personality structure (Avoidant, Dependent, Self-Defeating, Borderline). These were selected to reflect personality tendencies and diagnoses commonly exhibited in sexual abuse survivors. A series of hierarchical multiple regression analyses were conducted on the data. On the RQ the women most often described themselves as Fearful (58%) and Dismissing (16%), descriptions significantly different from the normative sample, who described themselves as 49% Secure and only 21% Fearful. Regression analysis of the MCMI and the RQ indicated that scores on the Avoidant scale were predicted by adult attachment, particularly Fearful attachment ($\beta = .2877$, $\underline{t} = 3.129$, $\underline{p} = .0023$). Dependent personality was best explained by the Preoccupied attachment status ($\beta = .2686$, $\underline{t} = 2.950$, $\underline{p} = .0039$) and by the Dismissing attachment ($\beta = -.2552$, $\underline{t} = -2.785$, $\underline{p} = .0064$). Self-Defeating personality was predicted by Fearful attachment ($\beta = .2438$, $\underline{t} = 2.587$, $\underline{p} = .0111$) and Preoccupied attachment accounted for most of the variance ($\beta = .2312$, $\underline{t} = 2.563$, $\underline{p} =$

.0118). Finally, Borderline PD was also associated with Preoccupied attachment status ($\beta = .2568$, $t = 2.816$, $p = .0058$). The limitations of this study include its retrospective nature in reporting childhood memories. Longitudinal studies would eliminate that limitation by following children through their life span. Further, none of the studies discussed in this section used the AAI, which is considered the standard attachment measure. Use of the AAI would also make these studies more conducive to comparison.

As demonstrated in the previously reported studies, attachment status does correlate with PDs. Individuals with an AD are more likely to exhibit PD symptoms, particularly individuals with a preoccupied or avoidant style. The discussion of the relationship will continue as specific personality disorders are addressed in the following sections.

Borderline Personality Disorder. Perhaps no personality disorder has been researched as extensively as Borderline Personality Disorder (BPD). It has earned a reputation as being a difficult disorder to treat, primarily because of the instability in relationships. BPD is characterized by the DSM-IV as "a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (APA, 1994, p. 657). Included in this definition is the BPD patient's frantic effort to avoid abandonment, real or imagined. Several researchers and theorists have postulated that this fear of

abandonment is linked with insecure attachment during childhood. A BPD patient's high level of anxiety about attachment may lead to an enmeshed dependence on the attachment figure that, if frustrated, may give rise to an angry withdrawal (West, Keller, et al., 1993).

In a study by West, Keller, et al. (1993) the discriminatory ability of attachment pathology, along with other social and functional characteristics, to indicate BPD was researched. The study examined 146 consecutively admitted patients to a teaching hospital. Participants were excluded from the study for a number of reasons, including the presence of a psychotic disorder and the termination of an attachment relationship within the last year. Out of the 146 patients initially assessed, 115 stated that they had a current attachment figure as defined by Bowlby (1977). These patients were given the MCMI, the Symptom Checklist – 90—Revised (SCL-90-R), the Reciprocal Attachment Questionnaire (RAQ), the Mehrabian's Affiliative Questionnaire (MAQ), and the Interpersonal Dependency Questionnaire (IDQ). The MCMI has been shown to have the highest average intercorrelation among all methods of assessing individuals with BPD and was considered an excellent measure of this type of pathology. The three measures on attachment, the RAQ, MAQ, and IDQ, yield 23 scales. An analysis of covariance (ANCOVA) was used to analyze the data using three factors and one covariant. The three factors were a BPD diagnosis (levels

determined by MCMI score), marital status, and education; the covariant was age. Only four scales met the researchers' defined statistical criteria. The four scales all came from the RAQ: Secure Base ($F = 8.8$, $p = 0.004$), Feared Loss ($F = 16.2$, $p = 0.0001$), Compulsive Care Seeking ($F = 10.0$, $p = 0.002$) and Angry Withdrawal ($F = 9.1$, $p = 0.003$). After performing a multivariate analysis of variance (MANOVA) on these four scales to investigate their importance in the determination of BPD diagnosis using the MCMI, a correlation using a canonical variable was completed. The most significant correlation proved to be Feared Loss (0.86), which suggests that feared loss is the most characteristic attachment feature of BPD patients. There were several limitations to this study that should be noted. First, the study was performed exclusively on females. However, it should also be noted that this variable is consistent with the diagnostic features of BPD. According to the DSM-IV (APA, 1994), BPD is diagnosed predominately (about 75%) in females. The second limitation is that, as with many disorders, there may have been overlapping diagnoses, which could potentially impact the results of the study. Most of the MCMI items load on several domains, so the purity of the diagnosis may be questionable.

However, the results of the West, Keller, et al. (1993) study are consistent with other, smaller studies. Stalker and Davies (1995) investigated 40 sexually abused women who were participating in either group or

individual psychotherapy at an inpatient, outpatient, or counseling agency. After administering the AAI, the Global Assessment Scale (GAS), and the SCID-II, they discovered that 60% of the women were unresolved in respect to trauma/loss, and that these unresolved issues appeared to continue to affect their attachment relationships as measured by the AAI. Seven out of eight of the women who were diagnosed as BPD were also classified as unresolved on the AAI. This prevalence is higher than the normal percentage of individuals classified as unresolved. The authors postulate that this may have been due to the inexperience of the raters in scoring protocols of abuse survivors. When categories were forced, the unresolved women were alternately classified as preoccupied. This result is consistent with other research in this area (Patrick, Hobson, Castle, Howard, & Maughan, 1994). This study was very limited by its small sample size. Prior to forcing the categories, only a few subjects were assigned to any of the other AAI classifications (autonomous, dismissing, preoccupied). Perhaps in a larger sample the results would be different in that more individuals would be classified in each category. However, this study does bring up the important issue of addressing the lost attachment in the treatment of women who have been sexually abused.

Patrick et al. (1994) conducted another small study on BPD and attachment styles. This particular study compared individuals with BPD to

Dysthymic patients with no characteristics of BPD, and sought to determine whether a particular mental organization corresponded to BPD. Dysthymic patients were chosen because the researchers believed that these patients would be comparable to BPD patients in age, sex, and intellectual status. Further, they postulated that the Dysthymic group would likely be comparable to BPD patients in mood, thereby eliminating depressive mood as a confounding variable that could be present in other samples. The authors hypothesized that Dysthymic patients would not manifest the kinds of disruptive mental processes, particularly splitting and projective identification, that those with the BPD diagnosis would display. The sample of 24 (12 Dysthymic, 12 BPD) was administered the AAI, the Parental Bonding Scale (a self-report measure) and the Beck Depression Inventory (BDI). The diagnosis of either BPD or Dysthymia was made on the basis of case notes employing DSM-III-R checklists. All BPD patients met seven out of the eight DSM-III-R criteria and none of the patients had comorbid diagnoses, this strengthening the results of the study (Fonagy et al., 1996). On the AAI, an individual blind to diagnosis interviewed the subjects, and the transcripts were rated by trained individuals blind to the diagnosis and the nature and aims of the study. Fisher's exact test statistics were calculated on the test data, as well as chi-square statistics for an overall result pattern. On the AAI, all 12 of the BPD patients were classified as

preoccupied (p = .0013). Of the 12 individuals in this category, 10 fell into a specific subcategory, which is characterized by attachments that are "confused, fearful, and overwhelmed." Further, 9 of the 12 BPD patients were classified as unresolved to trauma/loss (p = .012), while only 2 of the12 Dysthymic individuals were classified as unresolved. In the AAI interviews, the BPD patients reported a more traumatic childhood that included regular beatings and sexual abuse (Patrick et al., 1994).

The results in the previous study done by Patrick et al. are quite dramatic and remarkable. Other research, though finding similar results, has not been able to match the magnitude of these findings. In a study by Fonagy et al. (1996), the researchers studied a less homogenous group of non-psychotic hospitalized patients. The subjects were selected from a hospital in England known for its treatment of severe personality disorders through individual and group psychoanalytic therapy. Eighty-two inpatient individuals were matched on age, gender, social class, and verbal IQ with individuals from the outpatient department of a university teaching hospital. The two groups were interviewed using the SCID-II to determine diagnosis, the AAI for attachment styles and various self-report measures on psychiatric symptoms. Of the inpatient sample, 88% had an Axis I disorder, 72% had an Axis II disorder, 44% of which were BPD. Chi-square analysis revealed that 75% of the BPD sample was classified as preoccupied on the AAI (p = .05)

when the AAI categories were forced. Unforced category analysis revealed a significant number of BPD individuals classified in the same subcategory as the Patrick et al. (1994) study ("confused, fearful, and overwhelmed"). This result appears to be related to the larger numbers of BPD patients with histories of physical and/or sexual abuse (89%) in this sample. The two previously reported studies lend larger support to the notion that individuals with BPD are more likely to have fearful and preoccupied attachment styles, particularly if they have been sexually abused (Patrick et al, 1994; Fonagy et al., 1996).

Finally, with regard to theory and research, Sack et al. (1996) examined the relationship between an individual's object relations and attachment style. The two theories, psychodynamic object relations and attachment, overlap in many areas. However, to date, attachment has been more thoroughly researched. The Sack et al. (1996) study results are consistent with the aforementioned studies. The researchers investigated 53 undergraduate students and 49 psychiatric patients, diagnosed as BPD or as having BPD features. Subjects were administered the Attachment Style Inventory (ASI), which is a Likert scale measuring styles of attachment, the RAQ, the Hazan and Shaver's Attachment Self-Report, the Bell Object Relations Reality Testing Inventory, and the Attachment History Adjective Sort. Although they did not utilize the AAI, a sufficient number of

attachment measures were used. A MANOVA yielded significant results on the ASI (F 5, 68 = 20.94, $p < .001$). The BPD sample strongly endorsed ambivalent, avoidant, and hostile styles. A chi-square was performed on the ASI results and relationship categories (father, mother, friendship, sexual) and was significant at the $p < .001$ level. It appears from the results that the BPD sample endorsed avoidant attachment most frequently with friendships and fathers, and was more ambivalent about attachment with mothers and sexual partners. Although the study focused exclusively on females and college students, its results are consistent with other research. The study particularly highlighted the importance of feared loss in attachment for individuals with BPD.

In conclusion, the current research on BPD and attachment indicates that this PD is most closely associated with an insecure-preoccupied or hyperactivating attachment style. Individuals who have been a victim of sexual abuse are particularly susceptible to unresolved attachments, which may be exhibited through BPD symptomatology.

Schizoid and Avoidant Personality Disorders. Though BPD can be characterized by unresolved or preoccupied attachment, Schizoid and Avoidant Personality Disorders can be closely associated with dismissing attachment or compulsive self-reliance. Researchers have investigated this connection in a series of studies with interesting results. First, however, it is

important to describe each disorder, along with the similarities and differences between them.

According to the DSM-IV, Schizoid PD is characterized by a detachment from social relationships along with a restricted range of expressed emotion. Typically, individuals diagnosed with Schizoid PD neither desire nor enjoy close relationships, including family and sexual relationships. Schizoid individuals tend to prefer solitary activities and lack close friends or confidants. This tendency is usually coupled with emotional coldness and detachment from others. Avoidant PD is distinguished from Schizoid PD in that Avoidant individuals usually desire attachment but are fearful of rejection; persons with Avoidant PD struggle with feelings of inadequacy and are exceptionally sensitive to negative evaluations. Out of a fear of rejection, they tend to avoid activities that involve interpersonal contact. These individuals are wary of interactions with others, unless they are certain that they will be liked and accepted. Often they appear socially inept or unappealing and may lack social skills (APA, 1994).

West et al. (1995) investigated the relationship between the two disorders. The researchers noted in their study that there are two particular streams of thought regarding the characteristics and differences between Schizoid and Avoidant PD individuals. The first stream of thought is found in the DSM, which characterizes Schizoid individuals as having a lack of

desire for closeness, and Avoidant individuals as having a desire for closeness but an associated fear of intimacy. The alternative stream of thought is the one that West et al. (1995) adopted. The hypothesis is that the two disorders are quite similar and may be collectively characterized as avoidant or dismissing disorders of attachment. Attachment theorists view the

> search for safety and security through an attachment relationship as grounded in the biology of human experience. The avoidant stance evolves from experiences that lead to the belief that safety and security can only be achieved by shutting down expressions of attachment needs. (West et al., 1995, p. 411)

The West et al. study was based on the Avoidant and Schizoid individuals experience the desire for closeness. Participants were volunteer psychiatric outpatients drawn from consecutive admissions at a hospital in Canada (N = 146). Of the 146 individuals, 33 responded negatively to the statement "Is there someone in your life now whom you would describe as your attachment figure?" (West et al., 1995, p. 412). These individuals were given the Avoidant Attachment Questionnaire (AAQ) and the MCMI. Although still in development by the authors at the time of the study, the AAQ demonstrated a satisfactory degree of internal consistency (coefficient alpha ranged between .72 to .88). As noted earlier, the MCMI is considered an empirically valid measure of personality disorders, and the researchers chose the base rate (BR) of 84 as the cutoff for a pronounced disorder. The BR scores were used to divide the sample into two groups: those with BR equal to or greater

than 84 on the scales measuring avoidant and schizoid traits (n = 13), and those individuals who scored below 84 on these two scales (n = 20). An ANOVA demonstrated a statistically significant difference between the two groups on the AAQ scales of attachment. Significant results were found in the following AAQ scales: Maintains Distance (F 1, 31 = 30.30, $p < 0.0011$); High Priority on Self- Sufficiency (F 1, 31 = 8.24, $p = 0.007$); and Threat to Security (F 1, 31 = 10.44, $p = 0.003$). It is important to note that on the final scale of the AAQ "Desire for Close Affectional Bonds" the two groups did not differ, indicating that both individuals with Schizoid PD and Avoidant PD desire close relationships at least equally as much as the control group. The clinical sample with Avoidant and/or Schizoid PDs was very small (n = 33), which may have been indicative of the rarity of the PDs in the population. Further, selection bias was present in that the participants voluntarily presented themselves to services at the outpatient clinic. Finally, the study did not directly compare the differences and similarities between Avoidant and Schizoid PD. The commonality was implied by their combined difference from the control group and their similar score on the Desire for Close Affectional Bonds scale. Perhaps if the two groups were researched independently, more differences would surface. This research does, however, lend support to the attachment view of personality which includes the desire for attachment in both Avoidant PD and Schizoid PD, as opposed to the DSM

approach which distinguishes the disorders according to desire for attachment. In summary, according to the research by West et al., individuals desire closeness and attachment, although some may be more fearful of the rejection and shame associated with it.

Individuals with Avoidant PD have also been characterized by the DSM-IV (APA, 1994) as having poor social skills. Sheldon and West (1990) investigated the relationship of low social skills and attachment pathology in Avoidant PD. They argued that Avoidant PD is the result of attachment pathology and not poor social skills alone. Much of the research on Avoidant PD todate has focused exclusively on poor social skills and has neglected the attachment aspect of this disorder. The subjects ($N = 47$) were administered a 25-item self-report which yielded information on three scales: Desire for an Attachment Relationship, Fear of an Attachment Relationship, and Lack of Social Skills. Each item was rated on a 5-point scale. Participants were individuals who had received a clinical diagnosis of Avoidant PD and had stated that they did not have a current attachment figure. An ANOVA confirmed the hypothesis "that the desire for an attachment relationship and fear of an attachment relationship are more characteristic of this group of patients than lack of social skills (F 1, 38 = 14.73, $p = 0.0002$)" (Sheldon & West, 1990, p. 597). Based on self-evaluation these individuals are better characterized by a high desire for attachment combined with high fear of

such a relationship than by lack of social skills alone. Although this research did not use the standard attachment measures (i.e., AAI), it yielded results similar to those found in other studies. The study was weakened by the small sample size and by the fact that most of the patients had comorbid diagnoses that may have confounded the results.

A further aspect of Schizoid PD and attachment may be compulsive self-reliance as described by Bowlby (1977). He described the defensive organization of attachment systems as being one of four patterns of relating. An anxious enmeshment constructs the attachment around either seeking care (compulsive care seeking—CCS) or giving care (compulsive care giving—CCG). A lack of confidence in the attachment figure's reliable availability may lead to an emphasis on self-sufficiency (compulsive self-reliance--CSR) or generalized anger toward the attachment figure (generalized anger—GA). Patterns of insecure attachment range along this continuum from close, preoccupied patterns, to distant detached patterns. A study by West et al. (1994) investigated two of these patterns of attachment, CSR and CCS. (The description of the CCS results will follow in the next section.) The authors proposed that individuals with Schizoid PD would be characterized by CSR. They administered 4 self-report scales that were based on theoretical constructs and were being studied as part of a larger research project. The self-reports yielded satisfactory coefficients for internal reliability, ranging

from .65 to .81. The control group consisted of individuals who responded to a survey in the Canadian community, and the clinical group consisted of patients from an outpatient facility whose current diagnosis was not Schizophrenia or organic disorders. Both groups were administered the MCMI along with the 4 self-report measures. Of the 110 participants in the clinical group, 21 had scores above a BR of 84 on the Schizoid scale of the MCMI thereby indicating a probable diagnosis. These individuals also had a higher degree of CSR as determined by the results of Linear Regression Modeling (β 3.54, $p = .001$). These findings are consistent with other research in this area. According to this study it appears that Schizoid individuals build their working model of relatedness primarily around investment in their self. This working model often excludes the possibility of healthy reliance on others. Attachment theorists would argue that these individuals do desire closeness and reliance on others but fear rejection and abandonment. These patterns of relatedness may have developed in response to family interactions that posed a threat to the consistent availability of parental care and emotional support needed by all individuals. Defensive strategies, such as CSR, are then created to protect the individual from harm.

In conclusion, dismissing/avoidant attachment appears to characterize both Schizoid and Avoidant PDs. These individuals may be fearful of dependence on another and may react with excessive self-reliance and/or

distance. Perhaps early caregivers were not available and attentive, contributing to this need for painful dismissal of current attachments.

Other Personality Disorders. The remaining PDs discussed, Dependent, Self-Defeating, and Antisocial, have been subject to only a small number of studies. However, they are important in that they serve to confirm the earlier hypothesis of the impact of attachment on personality.

The DSM-IV (APA, 1994) describes Dependent PD as essentially the "pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood" (p. 668). Among other criteria, these individuals have difficulty making decisions, need others to assume responsibility, and go to excessive lengths to obtain nurturance. In the West et al. (1994) study mentioned above, Dependent PD was also studied. Contrary to Schizoid PD, which was found to be associated with CSR, Dependent PD was associated with compulsive care-seeking (CCS). In the clinical group, 42 individuals scored above a BR of 84 on the MCMI on the Dependent Personality Scale. This group also demonstrated a significant degree of CCS in comparison with the other clinical patients and the normal control sample (β 3.62, $p < .001$). There was a significant effect of gender on CCS, with females having significantly higher scores; however, there was no evidence of an interaction between gender and Dependent PD. The authors concluded that individuals with

Dependent PD may attempt to limit and bind fearfulness in a concrete manner by demonstrating urgent and frequent care seeking behavior. As noted earlier, this constant care seeking behavior may be an aspect of a preoccupied attachment style in which the individual does not feel secure in the relationship (West, Rose, et al., 1993).

In the DSM-IV criteria of Dependent PD, poor attachment relationships are not mentioned. Poor attachment may be implied by some of the criteria, but it is not an essential feature of the diagnosis. However, research conducted by Livesley et al. (1990) demonstrated that attachment pathology should indeed continue to be considered in the diagnosis and treatment of Dependent PD. They found that Dependent PD is a two-factorial disorder: insecure attachment and dependency. Self-report scales indicated that insecure attachment is not necessarily an aspect of dependency, but that insecure attachment and dependency are two traits that manifest themselves differently in Dependent PD. T-tests comparing a control group and outpatients with a PD diagnosis revealed that the clinical group obtained significantly higher scores on every dimension of the self-report measures indicating more difficulty with both attachment pathology and dependency. Although this study did not compare those with Dependency PD and those without on measures of attachment it does yield useful information. It suggests that attachment pathology is an important

causal factor in the development of Dependent PD, and its importance should be noted in the diagnosis and treatment of such individuals.

Antisocial PD has long been associated with lack of remorse, shallow affect, hyperactivity, and deficits in attachment. According to the DSM-IV (APA, 1994), it is a "pervasive pattern of disregard for and violation of the rights of others" (p. 649). Criminal populations appear to have a larger than normal number of antisocial individuals and therefore are an excellent arena in which to conduct research (IJendoorn et al., 1997). In a study by Gacono and Meloy (1991), the researchers used the Rorschach Inkblot Technique to measure several aspects of antisocial behavior, including attachment. Administration of the Rorschach on normal individuals typically yields a number of texture responses (T). T-responses have been associated with interpersonal closeness or affectional relatedness. Decreased numbers of such responses have been found in several populations, including foster-home children and conduct-disordered adolescents. The subjects of this particular study were 42 male felony offenders who met the criteria for Antisocial PD according to the DSM-III-R. All subjects were voluntary participants who were free of a diagnosis of schizophrenia, mental retardation, or bipolar illness. The participants were administered several measures, including the Rorschach, which was scored using the Comprehensive System by Exner (1986). A rater blind to the psychopathology or interview data scored the

Rorschach protocols. Means, standard deviations, and frequencies were determined for T-responses and were compared across the sample using chi-square analysis. Confirming the researcher's hypothesis, texture responses were infrequently produced in this population (Gacono & Meloy, 1991). Data collected by Exner of non-patient adults revealed that 90% of individuals produced texture responses (Exner, 1986). This percentage is compared to only 5% of Gacono and Meloy's criminal population (Gacono & Meloy, 1991). The virtually T-less records of these individuals with severe psychopathology support the profound detachment that characterizes these individuals. Perhaps these individuals use compulsive self-reliance to ward off feelings of vulnerability, dependency, or envy. This study lends support to understanding attachment in relation to antisocial behavior as well as supports the use of the Rorschach in assessing attachment.

Finally, although Self-Defeating PD is not currently a DSM-IV diagnosis, it is relevant to clinicians. It has been suggested that self-defeating behavior, or masochism, is in part the result of one having been raised by parents who, because of their own depression or narcissism, provided erratic nurturing (Williams & Schill, 1993). Often those with a Self-Defeating PD choose people who disappoint them, reject attempts of others to help them, and incite anger and rejection in others. It can then be expected that they would report anxious-ambivalent and avoidant attachment

histories. Williams and Schill (1993) confirmed this in a small, simple study. Subjects from an introductory psychology class were administered the Self-Defeating Personality Scale, a 48-item scale designed to assess Self-Defeating PD. The subjects were also given three paragraphs describing the characteristics associated with particular attachment styles (anxious, avoidant, healthy). The participants rated on a 5-point scale the extent to which the paragraph characterized their relationships with their mothers and fathers while growing up. Comparisions between the two measures indicated a positive correlation for men between self-defeating scores and avoidant attachment scores for mothers ($r = .46$, $p < .05$) and fathers ($r = .29$, $p < .05$). Though the correlations between self-defeating scores and anxious attachment were positive for both parents, only the correlation for mother was significant ($r = .43$, $p < .05$). For women, the two significant correlations were between high self-defeating scores and both anxious ($r = .22$, $p < .05$) and avoidant ($r = .31$, $p < .05$) attachment scores for mother. This study highlights the impact of mothers on the development of self-defeating personality characteristics, particularly in women. It is important to note that, in this study, the participants' responses were based on recollection and perceptions of their childhoods and may not be accurate.

In short, these small studies again highlight the importance of attachment in the development of PDs. More research on these disorders is

likely to continue to define the characteristics of PDs in light of attachment relationships.

Implications for Further Research

The studies in this review demonstrate the need for further research that examines the relationship between childhood attachment and adult disorders. New research may strive to correct some of the methodological difficulties encountered in many of the studies reviewed in this paper.

Longitudinal studies would be helpful to further examine the link between childhood and adult mental representations of attachment. This type of study would be much more reliable than the use of self-reports of past attachment. These studies could help answer questions about why some individuals with childhood attachment problems develop adult PDs and why some do not. Attachment status and later PDs may both be products of a common third factor, such as maternal sensitivity or the quality of the home environment. Further research would clarify the relationship (Paterson & Moran, 1988). Longitudinal research could also address the long-term effects of poor parent-child attachments. Finally, longitudinal research may also be useful in evaluating the effectiveness of child psychotherapy in resolving some of the attachment difficulties. According to Fonagy et al. (1996),

> [One] cannot be confident that attachment classification is independent of symptomatic presentation and thus can be appropriately considered either a general risk factor or an indicator of a predisposition to particular types of disturbance. Longitudinal studies are urgently needed to demonstrate the predictive value of adult attachment classification for the development of psychopathology. (pp. 29-30)

With the development of the AAI, research on attachment is becoming more standardized. However, many of the studies reviewed did not utilize this measure, thus making direct comparisons more difficult. Perhaps a test measuring attachment in children would also be useful in the proposed longitudinal studies mentioned above.

Further research on the relationship between attachment disorders, particularly unresolved attachment, Borderline Personality Disorder, and childhood sexual abuse would be helpful in treatment planning for these individuals. At present, there is a significant relationship between the three, but it is unclear if BPD is the best classification for these individuals. The distinctions between the effects of childhood sexual abuse and BPD need to be more fully clarified.

Finally, research needs to be conducted on how best to disseminate knowledge about personality disorders and attachment disorders to the individuals who might be at high risk for developing them. Psychiatrists, social workers, psychologists, and so forth, would also benefit from increasing their knowledge on the topic in order to better serve this population.

Implications for Treatment

It is apparent that preventative strategies rather than remedial ones will be the most effective in the treatment of PDs and ADs. By the time an individual is an adult, the patterns of attachment behavior are pervasive and difficult to change. Considering this research it appears that treating children with ADs may help to prevent the development of an adult PD.

A study by Dozier (1990) looked at the impact one's attachment strategy has on treatment. She found that individuals approach treatment in a manner consistent with their attachment strategy. More specifically, those individuals with a hyperactive strategy are typically highly motivated for treatment due to the high levels of distress they report. In contrast, individuals with a dismissing strategy are more likely to refuse or reject help and be less involved in their treatment planning. This study has explicit implications for doing therapy with individuals with attachment disorders. One's "internal working model of attachment may be self-perpetuating because the individual acts in a way so as to elicit responses from the environment consistent with expectations" (Dozier, 1990, p. 49). Therefore, according to many researchers, the individual needs a new experience through a therapeutic relationship. Research has found that women who did not perpetuate the cycle of abuse with their own children were more likely to

have spouses or therapists who had disconfirmed the women's earlier views of attachment in the world (Dozier, 1990).

The concept of an internal working model of attachment bears significant resemblance to ideas in both psychoanalytic and objects relations theories (Allen et al., 1996). In a therapeutic relationship patients may be able to relinquish omnipotent or infantile attitudes and self-perceptions and begin to accept themselves as they really are. Disappointments, letdowns, rejections, and failures may be experienced within the consistent, safe, and available therapeutic relationship (Whiteley, 1994). Johansen (1984) discussed several aspects of this therapeutic relationship. First, the therapist must work from within the transference, with transference defined as an attempt by the patient to recreate the type of attachment to the therapist that has been maintained by parents. The therapist must be willing to provide a secure base from which the patient can roam and develop a sense of security. Second the therapist must show an empathic appreciation of the patient's need for this base, including an understanding of "acting out," which may actually be in response to the patient's own feelings that the secure base has become threatened. Third, the therapist must encourage exploration from the secure base in order to counter anxious and insecure attachment as well as overdependence. Individuals with ADs may become possessive and exclusive about their relationships with their

therapists. Through confronting this, these therapists may further facilitate the growth of their patients.

Special attention should also be paid to individuals with AD and their responses to loss. "The experience of loss could make an anxiously attached person even more conscious of the precariousness of attachments, and the compulsive self-reliant individual yet more reluctant to engage in them" (Paterson & Moran, 1988, p. 617). This unresolved grief is likely to be exacerbated if the relationship with the individual was ambivalent as in the case of patients with preoccupied-hyperactive attachment. The feelings of unresolved loss and grief can also be addressed in therapy. By becoming the secure base for the patient, experiences of separation and loss can be explored in the therapy, particularly those arising in relationship to the therapist's absences due to illness or vacation (Sable, 1983).

Conclusion

The importance of this topic can not be underestimated. As individuals mature, their first attachment relationship to parents is likely to become less intense, and new attachments are likely to be formed with friends and spouses. Yet attachment behavior is active, and lasting throughout life. It is more likely to be aroused during times of illness, fatigue, fear, and so forth. Wanting and needing attachment figures at these

times is natural and is not considered childish or insecure (Sable, 1983). However, when individuals are not able to attach to another or live in fear of that attachment, difficulties arise. Chronic separation, threats of abandonment, unreliable caretaking, or parental rejection, may lead to the development of a false self or PD as individuals attempt to protect their fragile egos (Sable, 1983).

Research seems clearly to indicate that there is a significant relationship between attachment status and personality disorders. Individuals with a preoccupied-hyperactive attachment status are more likely than the general population to have BPD or Dependent PD. Those individuals with a dismissing or avoidant attachment strategy are more likely to be diagnosed with Schizoid, Avoidant, or Antisocial PD. Additionally, there is an interesting relationship among childhood sexual abuse, BPD, and an unresolved attachment status. Not only does attachment affect the development of a PD, but it also affects the development of psychopathology in general, and therefore the approach to treatment as well. By acknowledging the importance of attachment difficulties and their long-term ramifications, the psychological community can better address a large percentage of the individuals seeking assistance.

Individuals with AD seem to respond best to psychotherapy that focuses on the relationship between the patient and therapist. In the context

of this relationship they are better able to address their attachment fears and gain a new experience.

According to Paterson and Moran (1988), attachment status affects not only the individuals themselves, but also those in relationship with them. Parents who were described as having avoidant attachment tended to be the parents of insecure-avoidant children. Likewise, parents described as having a preoccupied attachment and who had often idealized their relationships with their own parents frequently had children categorized as insecure-ambivalent. A final group of parents who had experienced the death of an attachment figure in childhood and had not successfully resolved that loss had infants described as insecure-disorganized/disoriented.

Much of the meaning and satisfaction found in daily life comes from the security and closeness of relationships with significant others. Many feelings such as joy, sadness, anxiety, or anger reflect themselves in the context of relationship. It is hoped that through corrective experiences those individuals with attachment disorders and/or personality disorders will be able to improve their ability to make and maintain creative and secure bonds with others, and, therefore, enjoy and grow in reciprocal relationships.

REFERENCES

Ainsworth, M. D., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the strange situation. Hillsdale, NJ: Erlbaum.

Alexander, P. C. (1993). The differential effects of abuse characteristics and attachment in the prediction of long-term effects of sexual abuse. Journal of Interpersonal Violence, 8, 346-362.

Allen, J. P., Hauser, S. T., & Borman-Spurrell, E. (1996). Attachment theory as a framework for understanding sequelae of severe adolescent psychopathology: An 11-year follow-up study. Journal of Consulting and Clinical Psychology, 64, 254-263.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders. (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders. (4th ed.). Washington, DC: Author.

Bowlby, J. (1977). The making and breaking of affectional bonds. British Journal of Psychiatry, 130, 201-210, 421-431.

Burge, D., Hammen, C., Davila, J., Daley, S. E., Paley, B., Lindberg, N., Herzberg, D., & Rudolph, K. D. (1997). The relationship between attachment cognitions and psychological adjustment in late adolescent women. Development and Psychopathology, 9, 151-167.

Dozier, M. (1990). Attachment organization and treatment use for adults with serious psychopathological disorders. Development and Psychopathology, 2, 47-60.

Dozier, M., & Lee, S. W. (1995). Discrepancies between self- and other-report of psychiatric symptomatology: Effects of dismissing attachment strategies. Development and Psychopathology, 7, 217-226.

Dozier, M., Stevenson, A. L., Lee, S. W., & Velligan, D. I. (1991). Attachment organization and familial overinvolvement for adults with serious psychopathological disorders. Development and Psychopathology, 3, 475-489.

Exner, J. (1986). The Rorschach: A comprehensive system: Vol 1, Foundations. (2nd ed). New York: Wiley.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., Target, M., & Gerber, A. (1996). The relation of attachment status, psychiatric classification and response to psychotherapy. Journal of Consulting and Clinical Psychology, 64, 22-31.

Gacono, C. B., & Meloy, J. R. (1991). A Rorschach investigation of attachment and anxiety in antisocial personality disorder. The Journal of Nervous and Mental Disease, 179, 546-551.

IJendoorn, M. H. van, Feldbrugge, J. T., Derks, F. C., de Ruiter, C., Verhagen, M. F., Philipse, M. W., van der Staak, C. P., & Riksen-Walraven, J. M. (1997). Attachment representations of personality-disordered criminal offenders. American Journal of Orthopsychiatry, 67, 449-459.

Johansen, K. (1984). Attachment theory in the treatment of hospitalized borderline patients. The Psychiatric Hospital, 15, 113-118.

Jones, E. E. (1996). Introduction to the special section on attachment and psychopathology: Part I. Journal of Consulting and Clinical Psychology, 64, 5-7.

Kestenbaum, C. J. (1984). Pathological attachments and their Relationship to affective disorders in adult life. The American Journal of Psychoanalysis, 44, 33-49.

Kobak, R. (1989). The Attachment Interview Q-Set. Unpublished document, University of Delaware at Newark.

Kobak, R. R., Cole, H., Ferenz-Gillies, R., & Fleming, W. (1989). A component process analysis of adolescent attachment patterns. Unpublished manuscript.

Kooiman, C. G., & Spinhoven, P. (1996). Psychoanalytical aspects of DSM-III-R personality disorders in a group of HIV seropositive homosexual males. Journal of Personality Disorders, 10, 195-201.

Livesley, W. J., Jackson, D. N., & Schroeder, M. L. (1992). Factorial structure of traits delineating personality disorders in clinical and general population samples. Journal of Abnormal Psychology, 101, 432-440.

Livesley, W. J., Schroeder, M. L., & Jackson, D. N. (1990). Dependent personality disorder and attachment problems. Journal of Personality Disorders, 4, 131-140.

Main, M., & Goldwyn, R. (1991). Adults Attachment Classification System. Version 5. Unpublished manuscript, University of California, Berkeley.

Paterson, R. J., & Moran, G. (1988). Attachment theory, personality development, and psychotherapy. Clinical Psychology Review, 8, 611-636.

Patrick, M., Hobson, R. P., Castle, D., Howard, R., & Maughan, B. (1994). Personality disorder and the mental representation of early social experience. Development and Psychopathology, 6, 375-388.

Pianta, R. C., Egeland, B., & Adam, E. K. (1996). Adult attachment classification and self-reported psychiatric symptomatology as assessed by the Minnesota Multiphasic Personality Inventory - 2. Journal of Consulting and Clinical Psychology, 64, 273-281.

Sable, P. (1983). Overcoming fears of attachment in an adult with a detached personality. Psychotherapy: Theory, research and practice, 20, 376-381.

Sack, A., Sperling, M. B., Fagen, G., & Foelsch, P. (1996). Attachment style, history, and behavioral contrasts for a borderline and normal sample. Journal of Personality Disorders, 10, 88-102.

Sheldon, A., & West, M. (1990). Attachment pathology and low social skills in avoidant personality disorder: An exploratory study. Canadian Journal of Psychiatry, 35, 596-599.

Stalker, C. A., & Davies, F. (1995). Attachment organization and adaptation in sexually-abused women. Canadian Journal of Psychiatry, 40, 234-240.

West, M., Keller, A., Links, P., & Patrick, J. (1993). Borderline disorder and attachment pathology. Canadian Journal of Psychiatry, 38, 16-22.

West, M., Rose, M. S., & Sheldon, A. (1993). Anxious attachment as a determinant of adult psychopathology. Journal of Nervous and Mental Disease, 181, 422-427.

West, M., Rose, M. S., & Sheldon-Keller, A. (1994). Assessment of patterns of insecure attachment in adults and application to dependent and schizoid personality disorders. Journal of Personality Disorders, 8, 249-256.

West, M., Rose, M. S., & Sheldon-Keller, A. (1995). Interpersonal disorder in schizoid and avoidant personality disorders: An attachment perspective. Canadian Journal of Psychiatry, 40, 41-44.

Whiteley, J. S. (1994). Attachment loss and the space between: Personality disorder in the therapeutic community. Group Analysis, 27, 359-387.

Williams, D., & Schill, T. (1993). Attachment histories for people with characteristics of self-defeating personality. Psychological Reports, 73, 1232-1234.

VITA

NAME:

Melissa T. Hopper

EDUCATION:

Rosemead School of Psychology Clinical Psychology	Psy.D.	(Cand.)
Rosemead School of Psychology Clinical Psychology	M.A.	1997
Liberty University Psychology	B.S.	1994

INTERNSHIP:

Metropolitan State Hospital Norwalk, CA	1999 -	2000

PRACTICA:

Augustus F. Hawkins Comprehensive Community Mental Health Center Outpatient/Inpatient Program	1998 -	1999
Biola Counseling Center Outpatient Program	1997 -	1999
Foothill Community Mental Health Center Child/Adolescent Outpatient Program	1996 -	1997

EMPLOYMENT:

Hacienda La Puente School District (Workman High School) Drug, Alcohol, Tobacco, Education (D.A.T.E.) Counselor	1997 -	1998
Foothill Community Mental Health Center	1997 -	1997

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

REPRODUCTION RELEASE

(Specific Document)

I. DOCUMENT IDENTIFICATION:

Title: The relationship between Attachment Status and Personality Disorders

Author(s): Melissa T. Hopper

Corporate Source: Biola University

Publication Date: 5/00

II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, *Resources in Education* (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic media, and sold through the ERIC Document Reproduction Service (EDRS). Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please CHECK ONE of the following three options and sign at the bottom of the page.

The sample sticker shown below will be affixed to all Level 1 documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

1

Level 1

☐

Check here for Level 1 release, permitting reproduction and dissemination in microfiche or other ERIC archival media (e.g., electronic) *and* paper copy.

The sample sticker shown below will be affixed to all Level 2A documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE, AND IN ELECTRONIC MEDIA FOR ERIC COLLECTION SUBSCRIBERS ONLY, HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

2A

Level 2A

☐

Check here for Level 2A release, permitting reproduction and dissemination in microfiche and in electronic media for ERIC archival collection subscribers only

The sample sticker shown below will be affixed to all Level 2B documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

2B

Level 2B

☐

Check here for Level 2B release, permitting reproduction and dissemination in microfiche only

Documents will be processed as indicated provided reproduction quality permits.
If permission to reproduce is granted, but no box is checked, documents will be processed at Level 1.

I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche or electronic media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries.

Sign here, please

Signature: Melissa T Hopper	Printed Name/Position/Title: Melissa T Hopper
Organization/Address: 1307 Shadow Lane, unit B Fullerton CA 92831	Telephone: (714)879-8781 FAX:
	E-Mail Address: Date: 5/4/00

(over)

III. DOCUMENT AVAILABILITY INFORMATION (FROM NON-ERIC SOURCE):

If permission to reproduce is not granted to ERIC, *or*, if you wish ERIC to cite the availability of the document from another source, please provide the following information regarding the availability of the document. (ERIC will not announce a document unless it is publicly available, and a dependable source can be specified. Contributors should also be aware that ERIC selection criteria are significantly more stringent for documents that cannot be made available through EDRS.)

Publisher/Distributor:
Address:
Price:

IV. REFERRAL OF ERIC TO COPYRIGHT/REPRODUCTION RIGHTS HOLDER:

If the right to grant this reproduction release is held by someone other than the addressee, please provide the appropriate name and address:

Name:
Address:

V. WHERE TO SEND THIS FORM:

Send this form to the following ERIC Clearinghouse:

However, if solicited by the ERIC Facility, or if making an unsolicited contribution to ERIC, return this form (and the document being contributed) to:

ERIC Processing and Reference Facility
1100 West Street, 2nd Floor
Laurel, Maryland 20707-3598

Telephone: 301-497-4080
Toll Free: 800-799-3742
FAX: 301-953-0263
e-mail: ericfac@inet.ed.gov
WWW: http://ericfac.piccard.csc.com